Town of Manchester, Connecticut

BENEFIT	OAP Plus $5	OAP $5/$10	OAP Basic
Costshares			
	In-Network services subject to copays	In-Network services subject to copays	In-Network services subject to copays
	Out-of-Network services subject to deductible	Out-of-Network services subject to deductible	
	and coinsurance; balance billing allowed	and coinsurance; balance billing allowed	
	$5 Office Visit Copay	$5 Office Visit Copay - PCP	$5 Office Visit Copay - PCP
	$50 Emergency Room Copay	$10 Office Visit Copay - Specialist	$50 Emergency Room Copay
		$50 Emergency Room Copay	
	Deductible - $250/$750	Deductible - $250/$750	
	Coinsurance - 80%	Coinsurance - 80%	
	$1,500/$4,500 OOP Max	$1,500/$4,500 OOP Max	
	Lifetime Maximum In-Network - Unlimited	Lifetime Maximum In-Network - Unlimited	Lifetime Maximum In-Network - Unlimited
	Lifetime Maximum Out-Of-Network - Unlimited	Lifetime Maximum Out-Of-Network - Unlimited	
Preventive Care			
Pediatric	No Copay	No Copay	No Copay
Adult	No Copay	No Copay	No Copay
Vision	No Copay	No Copay	No Copay
	Covered once every 24 months	Covered once every 24 months	Covered once every 24 months
Hearing	No Copay	No Copay	No Copay
	Screening part of physical exam	Screening part of physical exam	Screening part of physical exam
Gynecological	No Copay	No Copay	No Copay
Medical Services			
Medical Office Visit	$5 Copay	$5 Copay - PCP	$5 Copay
		$10 Copay - Specialist	
Outpatient PT/OT/ST/Chiro.	$5 Copay	$10 Copay	$5 Copay
	60 Combined Days	60 Combined Days	60 Combined Days
	per calendar year per member	per calendar year per member	per calendar year per member
Allergy Services	$5 Copay for office visits and testing	$10 Copay for office visits and testing	$5 Copay for office visits and testing
	No copay for injections	No copay for injections	No copay for injections
Diagnostic Lab & X-ray	Covered	Covered	Covered
Inpatient Medical Services	Covered	Covered	Covered
Surgery Fees	Covered	Covered	Covered
Office Surgery	Covered	Covered	Covered
Outpatient MH/SA	$5 Copay	$10 Copay	$5 Copay
Emergency Care			
Emergency Room	$50 Copay (waived if admitted)	$50 Copay (waived if admitted)	$50 Copay (waived if admitted)
	Sudden & Serious Guidelines	Sudden & Serious Guidelines	Sudden & Serious Guidelines
Urgent Care	$25 Copay	$25 Copay	$25 Copay
Ambulance	Covered	Covered	Covered

Town of Manchester, Connecticut

BENEFIT	OAP Plus $5	OAP $5/$10	OAP Basic
Inpatient Hospital			
General/Medical/Surgical	**Pre-cert only for Out-of-network**	**Pre-cert only for Out-of-network**	**Pre-cert only for Out-of-network**
Maternity (Semi-private)	Covered	Covered	Covered
Ancillary Services	Covered	Covered	Covered
Medication, Supplies			
Psychiatric	Unlimited days	Unlimited days	Unlimited days
Substance Abuse/Detox	Unlimited days	Unlimited days	Unlimited days
Skilled Nursing/Rehabilitation Facility	Covered up to 180 days per calendar year	Covered up to 180 days per calendar year	Covered up to 180 days per calendar year
Hospice	Covered	Covered	Covered
Outpatient Hospital			
Outpatient Surgery	Covered	Covered	Covered
Facility Charges	(Prior Authorization Required)	(Prior Authorization Required)	(Prior Authorization Required)
Diagnostic Lab & X-ray	Covered	Covered	Covered
Pre-Admission Testing	Covered	Covered	Covered
Other Services			
Durable Medical Equipment	Covered	Covered	Covered
Prosthetics	Covered	Covered	Covered
Home Health Care	Unlimited days (Prior Authorization Required)	Unlimited days (Prior Authorization Required)	Unlimited days (Prior Authorization Required)
Express Scripts			
Prescriptions	$5/$10/$20 to unlimited maximum Three Tier Formulary RX Rider	$5/$15/$25 to unlimited maximum Three Tier Formulary RX Rider	$5/$10/$20 to unlimited maximum Three Tier Formulary RX Rider

*** All benefits listed are for In-Network. For Out-of-Network benefits, please refer to your Employee Benefit Summary.**

**** All plans are Non-Gatekeeper. No referrals are required. No primary care physician is required.**

***** OAP Basic plan has no Out-of-Network benefit.**

STATE MANDATES are excluded from the OAP Plus $5 and OAP $5/10, but are included in the OAP Basic.

INFERTILITY: Coverage is subject to a $5,000 lifetime maximum for OAP Plus $5, OAP $5/10, and OAP Basic.

ELIGIBILITY: Dependent children to age 25 for ALL plans; effective July 1, 2010 dependent children covered to age 26 for medical and prescription plans due to the passing of the Health Care Reform Act of March 30, 2010.